# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935
Madison, WI 53708-8935
Fax #: (608) 251-3036
Phone #: (608) 266-2112

**Office Location:** 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

**PHARMACY EXAMINING BOARD**

## HOME MEDICAL OXYGEN PROVIDER ACCREDITING ORGANIZATIONS

In order to obtain a Home Medical Oxygen Provider license you need to be accredited by one of the following organizations:

| **Accrediting Organization (AO)** | **Contact Information** |
|---|---|
| Accreditation Commission for Health Care, Inc. (ACHC) | 139 Weston Oaks Court<br>Cary, NC 27513<br>(855) 937-2242<br>http://www.achc.org |
| American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC) | 330 John Carlyle Street, Suite 210<br>Alexandria, VA 22314<br>(703) 836-7114<br>http://www.abcop.org |
| Board of Certification/Accreditation (BOC) | 10451 Mill Run Circle, Suite 200<br>Owings Mills, MD 21117<br>(877) 776-2200<br>http://www.bocusa.org |
| Commission on Accreditation of Rehabilitation Facilities (CARF) | 6951 E. Southpoint Road<br>Tucson, AZ 85756<br>(888) 281-6531<br>http://www.carf.org/dmepos |
| Community Health Accreditation Program, Inc. (CHAP, Inc.) | 1275 K Street, NW, Suite 800<br>Washington, DC 20005<br>(202) 862-3413<br>http://www.chapinc.org |
| Healthcare Quality Association on Accreditation (HQAA) | 114 East 4th Street, Suite 200<br>Waterloo, IA 50703 or<br>P.O. Box 1948<br>Waterloo, IA 50704<br>(866) 909-4722<br>http://www.hqaa.org |
| National Association of Boards of Pharmacy (NABP) | 1600 Feehanville Drive<br>Mount Prospect, IL 60056<br>(847) 391-4406<br>http://www.nabp.net |
| The Compliance Team, Inc. | P.O. Box 160<br>905 Sheble Lane, Suite 102<br>Spring House, PA 19477<br>(215) 654-9110<br>http://www.thecomplianceteam.org |
| The Joint Commission | One Renaissance Boulevard<br>Oakbrook Terrace, IL 60181<br>(630) 792-5800<br>http://www.jointcommission.org |
| The National Board of Accreditation for Orthotic Suppliers (NBAOS) | 15000 Commerce Parkway, Suite C<br>Mount Laurel, NJ 08054<br>(856) 380-6856<br>http://www.nbaos.org |

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## HOME MEDICAL OXYGEN PROVIDER APPLICATION

**PLEASE TYPE OR PRINT IN INK** ☐ Your name, address, telephone number, and email address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

☐ NEW PROVIDER ☐ CHANGE OF OWNERSHIP ☐ CHANGE OF LOCATION

For change of ownership or location please provide **CURRENT LICENSE NUMBER: _____**- 48.

**FACILITY NAME and FEIN:**

**DBA:** If different from facility name, name or title under which business is operated. **(This must be the name on the provider label.)**

**DAYTIME TELEPHONE NUMBER:**

**FAX NUMBER:**

**FACILITY ADDRESS:** number, street, city, zip code

**MAILING ADDRESS UNTIL DAY OF OPENING (if applicable):** number, street, city, zip code

**EMAIL ADDRESS:**

**NAME OF OWNER OR NAMES AND TITLES OF ALL PARTNERS, CORPORATE OFFICERS AND SHAREHOLDERS OWNING ABOVE 20% OF VOTING STOCK:** (Attach additional sheets if necessary.)

| NAME | ADDRESS (City State Zip) | RPh? (Y/N) |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**APPLICATION FEE:** Please make check payable to DSPS and attach to application.

**$59.00** Initial Credential Fee

**For Receipting Use Only (48)**



#3075 (Rev. 6/19)
Ch. 450, Stats.

# Wisconsin Department of Safety and Professional Services

**Please answer the following questions:**

| | YES | NO |
|---|---|---|
| 1. Have the principals or applicant ever been charged with a felony or misdemeanor? **If yes, please complete Form #2252 and provide details about the crime, including date of conviction penalty, and a copy of the court documents**. (**Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges**.) | ☐ | ☐ |
| 2. Have any of the principals or applicant conducted a similar business in any other state? **If yes, please indicate license number/state issued below**. _____ _____ | ☐ | ☐ |
| 3. Has the applicant ever made application for a license to operate a Pharmacy, Drug/Device Manufacturer or Wholesale Distributor of Prescription Drugs? **If yes, was the application denied (and for what reason)**? _____ _____ | ☐ | ☐ |

4. Applicant proposes to sell medical oxygen to (**check all that apply**):

   ☐ Nursing homes ☐ Home Health Agencies ☐ Public ☐ Hospitals
   ☐ Ambulance Services ☐ Other: _____

5. Please list the applicant's Accrediting Organization (AO):
   _____

## AFFIDAVIT OF APPLICANT

CONTINUING DUTY OF DISCLOSURE

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

By signing below, I am signifying that I have read the above statements (Continuing Duty of Disclosure and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

_____ _____

**Signature of Applicant** **Date**